

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4488 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04478			
Item 9, Film G181 5-17-55 et CERTIFICATE OF DEATH			
1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Calvert</u>	MARYLAND	STATE <u>MD</u>	COUNTY <u>Calvert</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>PARAN</u>	
X TOWN <u>Dr. Frederick</u>	<u>8 days</u>	STREET ADDRESS (If rural give location) <u>1</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
DECEASED: (Type or Print) <u>Emma Brown</u>		OF DEATH: <u>5</u> <u>7</u> <u>1955</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED: (Specify): <u>MAR</u>	8. DATE OF BIRTH: <u>Dec 27, 1917</u>
9. AGE last birthday: <u>37</u> yrs.		IF UNDER 1 YEAR: Months Days	IF UNDER 24 HRS.: Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY:	11. BIRTHPLACE (State or foreign country): <u>Maryland</u>
13. FATHER'S NAME: <u>George Harold</u>		12. CITIZEN OF WHAT COUNTRY? <u>US</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk): <u>9</u>		17. INFORMANT & ADDRESS:	
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <u>490X</u>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <u>Acute Nephritis</u>			
DUE TO			
(B) <u>Pneumonia</u>			
DUE TO			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION: <u>0</u>	19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	21C. WHERE DID (City or town) (County) (State)	
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>4/29</u> 19 <u>55</u> , to <u>5/2</u> 19 <u>55</u> , that I last saw the deceased <u>alive</u> on <u>5/6/55</u> , 19 <u>55</u> , and that death occurred at <u>9:50 A</u> M, from the causes and on the date stated above.			
SIGNATURE <u>[Signature]</u>		DATE SIGNED <u>5/7/55</u>	
ADDRESS <u>[Address]</u>		M. D. <u>[Signature]</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
	<u>5-10-55</u>	<u>St. Edmonds</u>	<u>Smith</u>
DATE REC'D BY LOCAL REGISTRAR	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>5-10-55</u>	<u>N W. Ward</u>	<u>P. E. Sewell, Prince Fred. Md.</u>	

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MAY 12 1955

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PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04479

4489

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Calvert</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Calvert</i>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Huntingtown</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert County Hospital</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED: (First) <i>Sadie</i> (Middle) <i>Burton</i> (Last)				4. DATE (Month) (Day) (Year) OF DEATH: <i>5</i> <i>2</i> <i>1955</i>			
5. SEX: <i>F</i>	6. COLOR OR RACE: <i>white</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify): <i>wid</i>	8. DATE OF BIRTH: <i>11/23/1873</i>	9. AGE last birthday <i>81</i> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life. even if retired): <i>none</i>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>German town, MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>	
13. FATHER'S NAME: <i>Richard Trail</i>				14. MOTHER'S MAIDEN NAME: <i>Mollie Ward</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>9</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS: <i>Percy Burton. Huntingtown, MD</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
443X IMMEDIATE CAUSE (A) <i>Cerebral hemorrhage</i>							
ANTECEDENT CAUSE (S) DUE TO (B) <i>Hypertension c &amp; d</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>5/2</i> , 19 <i>55</i> , to <i>5/2</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>May 2</i> , 19 <i>55</i> , and that death occurred at <i>2:40</i> P.M. from the causes and on the date stated above.							
SIGNATURE <i>Richard Trail</i> M.D.				DATE SIGNED <i>5/2/55</i>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Burial</i>		<i>May 5 - 1955</i>		<i>Cedar Hill</i>		<i>Southland Maryland</i>	
DATE REC'D BY LOCAL REGISTRAR <i>5-2-55</i>		REGISTRAR'S SIGNATURE <i>H. W. Ward</i>		24. FUNERAL DIRECTOR <i>Simmons Brothers</i>		ADDRESS <i>Ward, DC</i>	

BUREAU V. S.

MAY 5 1957

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04480

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

4490

1. PLACE OF DEATH COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ch. Beach</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Ch. Beach</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>Samuel</u> (First) <u>LeRoy</u> (Middle) <u>Deets</u> (Last)		4. DATE OF DEATH <u>May</u> (Month) <u>21</u> (Day) <u>1955</u> (Year)	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>M. Binnello</u>	8. DATE OF BIRTH <u>22 Oct 1888</u>
10a. USUAL OCCUPATION (Give kind of work done during last of working life, even if retired) <u>Sales Mgr.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>M. Binnello</u>	9. AGE last birthday <u>66</u> yrs. <u>66</u> Months <u>21</u> Days <u>19</u> Hours <u>55</u> Min.
11. BIRTHPLACE (State or foreign country) <u>Garrettsville Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Mr F Deets</u>		14. MOTHER'S MAIDEN NAME <u>Sadie Gladden</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>212-07-4176</u>	
		17. INFORMANT AND ADDRESS <u>Mr Deets. Ch. Beach. Md.</u>	

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

163X Immediate cause

(a) Carcinoma of lung

Antecedent cause(s)

(b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last

(c)

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

## 19a. DATE OF OPERATION 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☐

21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN)	(COUNTY)	(STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?		

22. I hereby certify that I attended the deceased from 7-24, 1954, to 5/20, 1955, that I last saw the deceased alive on 5/20, 1955, and that death occurred at 4:35 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/24/55</u>	NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	LOCATION (City, town, or county) <u>Suitland, Maryland</u>
DATE REC'D BY LOCAL REG. <u>May 24/55</u>	REGISTRAR'S SIGNATURE <u>Grace L. Hutchins</u>	24. FUNERAL DIRECTOR ADDRESS <u>Ritchie Bros. Upper Marlboro, Md.</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



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JUN 3 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4491

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04481

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

Item 9, Film 181 5-16-55 et

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert County</u> MARYLAND				STATE <u>Maryland</u> COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Prince Frederick</u>				CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Fairhaven</u> <u>02x-2</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Calvert County Hospital</u>				STREET ADDRESS (If rural give location) <u>Anne Arundel Co.</u>			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year)			
<u>Laura A. Ferguson</u>				<u>5 2 1955</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>widow</u>		8. DATE OF BIRTH: <u>6-9-1872</u>	
9. AGE last birthday: <u>82 8/3</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>None</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>None</u>		11. BIRTHPLACE (State or foreign country): <u>Virginia</u>	
12. CITIZEN OF WHAT COUNTRY? <u>United States</u>							
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Grandmother Rock</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>None</u>				17. INFORMANT & ADDRESS: <u>Mr. Garrell Beitzell (son) Fairhaven, Md.</u>			
16. SOCIAL SECURITY NO. <u>None</u>							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE <u>153X</u>							
ANTECEDENT CAUSE (S):							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(A) <u>Carcinoma of Bowell</u>							
DUE TO							
(B)							
DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <u>0</u>				19B. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) INJURY OCCUR? (County) (State)			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>1 Mo</u> , 1955, to <u>5/2</u> , 1955, that I last saw the deceased alive on <u>5/2</u> , 1955, and that death occurred at <u>5:30</u> P. M. from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>				DATE SIGNED <u>5/2/55</u>			
ADDRESS <u>[Address]</u>				M. D. <u>Huntington</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 5/55</u>		NAME OF CEMETERY OR CREMATORY <u>Bedar Hill Cem</u>		LOCATION (City, town, or county) (State) <u>Prince Geo. Co., Md.</u>	
DATE REC'D BY LOCAL REGISTRAR <u>5-2-55</u>		REGISTRAR'S SIGNATURE <u>[Signature]</u>		24. FUNERAL DIRECTOR <u>Martin W. Nyson</u>		ADDRESS <u>1300 M. St N.W. Wash. D.C.</u>	

BUREAU V. S.

MAY 12 1955

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04482

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 52

1. PLACE OF DEATH: COUNTY <u>Calvert</u> MARYLAND CITY (If outside corporate limits write RURAL OR and give nearest town) <u>X</u> TOWN <u>Ches. Beach</u>		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md</u> COUNTY <u>Calvert</u> CITY (If outside corporate limits write RURAL and give nearest town) OR TOWN <u>Ches. Beach</u> <u>up</u> <u>X</u> STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED: (Type or Print) <u>Nettie</u> (First) (Middle) <u>Island</u> (Last)		4. DATE OF DEATH (Month) <u>5</u> (Day) <u>25</u> (Year) <u>1955</u>	
5. SEX: <u>7</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>W</u>	8. DATE OF BIRTH: <u>Nov. 16, 1872</u>
9. AGE last birthday: <u>82</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Unknown</u>		14. MOTHER'S MAIDEN NAME: <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) <u>no</u>		16. SOCIAL SECURITY No.: <u>                    </u>	
17. INFORMANT & ADDRESS: <u>Mrs. Robert Buckmaster Chesapeake</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
42201 Immediate cause (a) <u>acute dilatation of heart</u>		<u>1 hr</u>	
Antecedent cause(s) (b) <u>Chronic myocarditis</u>		<u>10 yrs</u>	
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <u>Arteriosclerosis</u>		<u>12 yrs</u>	
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION: <u>                    </u>		19b. MAJOR FINDING OF OPERATION: <u>Heart 4 km 5/25/55</u>	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY	21e. INJURY OCCURRED While at <input type="checkbox"/> Not while work <input type="checkbox"/> at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE <u>H. W. Ward</u>		M. D. CHIEF MEDICAL EXAMINER <u>5/25/55</u> DEPUTY MEDICAL EXAMINER <u>                    </u> ASSISTANT MEDICAL EXAM. <u>                    </u>	
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE THEREOF: <u>5/28/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Mt. Harmony Cem.</u>	LOCATION (City, town, or county) (State): <u>Mt. Harmony Md.</u>
DATE REC'D BY LOCAL REG. <u>May 28, 1955</u>	REGISTRAR'S SIGNATURE: <u>Grace L. Ketchum</u>	24. FUNERAL DIRECTOR: <u>H. Kuchelinski</u> ADDRESS: <u>Owings, Md.</u>	

MARGIN RESERVED FOR BINDING

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BUREAU V. S.

JUN 8 1955

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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

## CERTIFICATE OF DEATH

05427

Reg. Dist. No. 52

Item 9, File G182 6-14-55 et

1. PLACE OF DEATH - COUNTY <u>Calvert</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE <u>Md</u> COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Dunkirk</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Dunkirk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>17</u>		STREET ADDRESS (If rural, give location) <u>Md</u>	
3. NAME OF DECEASED (Type or Print) <u>Effie</u> (First)	<u>Rogers</u> (Middle)	<u>Jenkins</u> (Last)	4. DATE OF DEATH <u>May 29</u> (Month) (Day) (Year) <u>1955</u>
5. SEX <u>F</u> COLOR OR RACE <u>W</u>	7. SINGLE <input checked="" type="checkbox"/> MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> (Specify)	8. DATE OF BIRTH <u>2 June 1888</u>	9. AGE last birthday <u>66</u> yrs. <u>167</u> Months <u>66</u> Days <u>66</u> Hours <u>66</u> Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Sec.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>home</u>	
11. BIRTHPLACE (State or foreign country) <u>Md</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>William Rogers</u>		14. MOTHER'S MAIDEN NAME <u>Harriet Rogers</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No. <u>—</u>	
17. INFORMANT AND ADDRESS <u>Mrs. George J. Demal</u> <u>Huntingtown Md.</u>			

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

INTERVAL BETWEEN ONSET AND DEATH

4201	(a) <u>Coronary occlusion</u>	
Immediate cause	(b) <u>arteriosclerosis</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last	(c)	

11. OTHER SIGNIFICANT CONDITIONS  
Conditions contributing to the death but not related to the disease or condition causing death.

19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 4/1, 1947, to 5/29, 1955, that I last saw the deceased alive on 5/26, 1955, and that death occurred at 5:30 p.m., from the causes and on the date stated above.

SIGNATURE <u>J. Weemes</u>	(Degree or title) <u>M.D.</u>	ADDRESS <u>Huntingtown Md</u>	DATE SIGNED <u>5/31/55</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>6/1/55</u>	NAME OF CEMETERY OR CREMATORY <u>St. James</u>	LOCATION (City, town, or county) (State) <u>Tracy's Md.</u>
DATE REC'D BY LOCAL REG. <u>May 31, 1955</u>	REGISTRAR'S SIGNATURE <u>Grace L. Hutchins</u>	24. FUNERAL DIRECTOR <u>T. A. Waddell &amp; Son</u>	ADDRESS <u>Galesville Md.</u>

RECEIVED

JUN 9 1955

BUREAU V. S.

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4493

## CERTIFICATE OF DEATH

Reg. Dist. No. 04483 51

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>Calvert</i>		MARYLAND		STATE <i>MD</i>		COUNTY <i>Calvert</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>X</i> TOWN <i>Pr. Frederick.</i>		LENGTH OF STAY (in this place) <i>22.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Pr. Frederick.</i> <i>X</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>64 Calvert County Hospital</i>				STREET ADDRESS (If rural give location) <i>1</i>			
3. NAME OF DECEASED: (First) (Middle) (Last) <i>Fred Jones</i>				4. DATE (Month) (Day) (Year) OF DEATH: <i>5 - 7 - 1955</i>			
5. SEX: <i>m</i>	6. COLOR OR RACE: <i>Cahoid</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Single</i>	8. DATE OF BIRTH:	9. AGE last birthday <i>72</i> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <i>Calvert Co., Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>US</i>	
13. FATHER'S NAME: <i>Charles Jones</i>				14. MOTHER'S MAIDEN NAME: <i>Georganna Dawkins</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No. <i>215-14-7203</i>		17. INFORMANT & ADDRESS: <i>MAZIE MACKALL - Pr Frederick</i>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE (A) <i>Congestive - Heart Failure</i>							
ANTECEDENT CAUSE (S) <i>Malnutrition</i>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>April 15 58</i> , 19 <i>58</i> , to <i>May 7 58</i> , 19 <i>58</i> , that I last saw the deceased alive on <i>May 7 58</i> , 19 <i>58</i> , and that death occurred at <i>12:5 P</i> M, from the causes and on the date stated above.							
SIGNATURE <i>R. Williams</i>		M. D. <i>Strom</i>		DATE SIGNED <i>May 7/58</i>			
23. BURIAL CREMATION, REMOVAL (SPECIFY)		DATE THEREOF <i>5-11-55</i>		NAME OF CEMETERY OR CREMATORY <i>Carroll</i>		LOCATION (City, town, or county) (State) <i>Barstow, Calvert Md</i>	
DATE REC'D BY LOCAL REGISTRAR <i>5-10-55</i>		REGISTRAR'S SIGNATURE <i>N.W. Ward</i>		24. FUNERAL DIRECTOR <i>P.E. Sewell</i>		ADDRESS <i>Prince Fred, Md.</i>	



BUREAU V. S.

MAY 12 1955

RECEIVED

4494

04484

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

No. ....

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Calvert</i>	MARYLAND	STATE <i>MD</i>	COUNTY <i>Calvert</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <i>Laurel</i>	LENGTH OF STAY (In this place)	CITY (If outside corporate limits write RURAL and give nearest town) <i>Laurel</i>	OR TOWN
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED:		4. DATE OF DEATH	
(First) <i>Joseph</i>	(Middle) <i>Jones</i>	(Last) <i>Jr</i>	(Month) <i>5</i> (Day) <i>2</i> (Year) <i>1955</i>
5. SEX: <i>M</i>	6. COLOR OR RACE: <i>W</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED: <i>W</i>	8. DATE OF BIRTH: <i>Dec 26 1877</i>
9. AGE last birthday: <i>77</i> yrs.		10. IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <i>owner</i>		10b. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>MD</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <i>Joseph Jones</i>		14. MOTHER'S MAIDEN NAME: <i>Julia Foster</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <i>Yes</i> (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:	
17. INFORMANT & ADDRESS: <i>Mr. Joe Jones</i>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:		INTERVAL BETWEEN ONSET AND DEATH	
4343 Immediate cause (a) <i>Acute dilatation of heart</i>			
Antecedent cause(s) (b) <i>DUE TO</i>			
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c) <i>DUE TO</i>			
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH: <i>fat up &amp; voided, fell in floor &amp; died</i>			
19a. DATE OF OPERATION:		19b. MAJOR FINDING OF OPERATION:	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY	21c. (City or town) (County) (State)	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <i>5 2/55 630 A.M.</i>	21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	21f. HOW DID INJURY OCCUR?	
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
SIGNATURE: <i>H. W. Ward</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <i>5-12-55</i> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> M. D. ASSISTANT MEDICAL EXAM. <i>P. E. Sewell Prince Frederick Md</i>	
23. BURIAL, CREMATION, REMOVAL (Specify): <i>5-4-55</i>	DATE THEREOF: <i>5-4-55</i>	NAME OF CEMETERY OR CREMATORY: <i>Patuxent</i>	LOCATION (City, town, or county) (State): <i>Laurel Md</i>
DATE REC'D BY LOCAL REG. <i>5-3-55</i>	REGISTRAR'S SIGNATURE: <i>H. W. Ward</i>	24. FUNERAL DIRECTOR ADDRESS: <i>P. E. Sewell Prince Frederick Md</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

MAY 4 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4495

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 04485

## CERTIFICATE OF DEATH

Reg. Dist. No. 5-1

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Cabot</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Cabot</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
X TOWN <u>Prince Frederick</u>		1 mo.		TOWN <u>Solomons</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Cabot County Hospital</u>				STREET ADDRESS (If rural give location) <u>1</u>			
3. NAME OF DECEASED: (First) <u>Eliza</u> (Middle) <u>E.</u> (Last) <u>Jusky</u>				4. DATE OF DEATH: (Month) <u>May</u> (Day) <u>6</u> (Year) <u>1955</u>			
5. SEX: <u>F</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>W</u>		8. DATE OF BIRTH: <u>Nov. 14, 1868</u>	
9. AGE last birthday: <u>86</u> yrs.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u>		11. BIRTHPLACE (State or foreign country): <u>St. Mary's Co., Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.O</u>	
13. FATHER'S NAME: <u>Alfred Readmond</u>				14. MOTHER'S MAIDEN NAME: <u>Maya Myers</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>no</u>		16. SOCIAL SECURITY No.: <u>no</u>		17. INFORMANT & ADDRESS: <u>Guy A. Jusky - Solomons - Md</u>			
18. MEDICAL CERTIFICATION							Interval Between Onset And Death
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
466X Immediate cause (a) <u>Heart failure</u>							
Antecedent causes (s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (b) <u>thrombosis of left leg</u>							
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
19a. DATE OF OPERATION: 19b. MAJOR FINDINGS OF OPERATION							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>5/6</u> , 19 <u>55</u> , to <u>5/8</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>5/6</u> , 19 <u>55</u> , and that death occurred at <u>9 pm</u> , from the causes and on the date stated above.							
SIGNATURE <u>[Signature]</u>		(Degree or title)		ADDRESS <u>St. Leonard</u>		DATE SIGNED <u>5/20/55</u>	
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
Burial		May 9, 1955		Solomons M.E. Cem.		Solomons - Cabot Co., Md	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
5-9-55		H. W. Ward		A. A. Harkness & Son - Mutual, Ind.			

BUREAU V. S.

MAY 10 1955

RECEIVED



PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4496

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04486

## CERTIFICATE OF DEATH

Reg. Dist. No.

Calvert Co. Hosp.

## 1. PLACE OF DEATH:

COUNTY Calvert MARYLAND  
CITY (If outside corporate limits, write RURAL OR TOWN and give nearest town) Prince Frederick  
LENGTH OF STAY (in this place) 6 days

HOSPITAL OR  
INSTITUTION OR  
STREET ADDRESS

64 Calvert Co. Hosp.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE MD COUNTY Calvert  
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN Baytown

STREET ADDRESS (If rural give location) MD

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

CharlotteMac Gruder

## 4. DATE (Month)

(Day)

(Year)

5161955

## 5. SEX:

## 6. COLOR OR RACE:

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday

IF UNDER 1 YEAR

IF UNDER 24 HRS.

FNMarriedAug 1, 189955 yrs.

Months

Days

Hours

Min.

## 10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

## 10B. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

House wifeMD

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

Thomas PurveyHarriet Norris

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

## 16. SOCIAL SECURITY NO.

## 17. INFORMANT &amp; ADDRESS:

Daughter Thomas Prince Frederick

## 18. MEDICAL CERTIFICATION

## I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

## INTERVAL BETWEEN ONSET AND DEATH

331x

## IMMEDIATE CAUSE

(A)

DUE TO

Cerebral hemorrhage

## ANTECEDENT CAUSE (S)

(B)

DUE TO

Essential Hypertension

DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.

(C)

## II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.

## 19A. DATE OF OPERATION:

## 19B. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

YES ☐ NO ☒

## 21A. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

## 21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)

## 21C. WHERE DID (City or town) INJURY OCCUR?

(County)

(State)

## 21D. TIME (Month) (Day) (Year) (Hour) OF INJURY

M.

21E. INJURY OCCURRED While ☐ Not while ☐ at work ☐ at work ☐

## 21F. HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from May 10, 1955, to May 16, 1955, that I last saw the deceased

alive on May 16, 1955, and that death occurred at 9:50 M, from the causes and on the date stated above.

SIGNATURE

Robert Leonard S

M. D.

ADDRESS

St. Leonard

DATE SIGNED

5/16/55

## 23. (BURIAL) CREMATION, REMOVAL (SPECIFY)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

5-18-55Green PointCalvertMD

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

5-16-55W. W. WardP. E. Sevell Prince Frederick

BUREAU V. S.

MAY 23 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

4497

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04487

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Calvert</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Calvert</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Prince Frederick</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Rural. Paris Md.</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Calvert Co. Hospital</i>		STREET ADDRESS (If rural give location) <i>1</i>	
3. NAME OF DECEASED: (First) <i>Archie</i> (Middle) <i>Pembroke</i> (Last) <i>Norfolk</i>		4. DATE OF DEATH: (Month) <i>May</i> (Day) <i>13</i> (Year) <i>1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Married</i>	8. DATE OF BIRTH: <i>March 10, 1889</i>
9. AGE last birthday: <i>66</i> yrs. Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min.		10. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Farming</i>	
11. BIRTHPLACE (State or foreign country): <i>Calvert Co. Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>	
13. FATHER'S NAME: <i>John H. Norfolk</i>		14. MOTHER'S MAIDEN NAME: <i>Annie Griffith</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <i>9</i>		16. SOCIAL SECURITY No.: <i>—</i>	
17. INFORMANT & ADDRESS: <i>Mrs Carl Denton, Dwings Md.</i>		18. MEDICAL CERTIFICATION	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death <i>40 min</i>	
Immediate cause <i>434.3</i> (a) <i>Acute dilatation of heart</i>			
Antecedent causes (s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO			
(c) <i>went to bed and was taken in 5 min. Died enroute to Hospital</i>			
11. OTHER SIGNIFICANT CONDITIONS			
Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <i>0</i>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <i>—</i>		PLACE (Home, farm, factory, street, office bldg., etc.) <i>—</i>	
TIME (Month) (Day) (Year) (Hour) OF INJURY <i>—</i>		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>	
HOW DID INJURY OCCUR? <i>—</i>			
22. I hereby certify that I attended the deceased from <i>1/12/55</i> to <i>5/14/55</i> , 19 <i>55</i> , that I last saw the deceased alive on <i>5/14/55</i> , 19 <i>55</i> , and that death occurred at <i>1/12/55</i> from the causes and on the date stated above.			
SIGNATURE <i>Harold Duane</i>		ADDRESS <i>5/14/55</i>	
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>May 16, 1955</i>	
NAME OF CEMETERY OR CREMATORY <i>W.F. Harmony Cemetery</i>		LOCATION (City, town, or county) <i>Dwings Md.</i>	
REGISTRAR'S SIGNATURE <i>Grace L. Hutchins</i>		24. FUNERAL DIRECTOR <i>W.F. Hutchins, Dwings Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>May 16, 1955</i>			

RECEIVED  
MAY 19 1967  
BUREAU V. S.

Item 7, Film 182 6-21-55 et

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 52

05432  
Reg. Dist.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Calvert</u>	MARYLAND	STATE <u>Pa</u>	COUNTY
CITY (If outside corporate limits, write RURAL OR and give nearest town)	LENGTH OF STAY (in this place)	CITY (If outside corporate limits write RURAL and give nearest town)	
TOWN <u>Bellevue</u>		TOWN <u>Bellevue</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Collier's Lumber &amp; Hardware</u>		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED: (Type or Print) <u>Collier's Lumber &amp; Hardware</u>		4. DATE OF DEATH <u>5-22-55</u>	
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Divorced</u>	8. DATE OF BIRTH: <u>1908-4-7</u>
9. AGE last birthday: <u>47</u> yrs.		10. IF UNDER 1 YEAR: Months <u>5</u> Days <u>22</u> Hours <u>19</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Grand Operator</u>		11. BIRTHPLACE (State or foreign country): <u>Pa</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME: <u>James Milton Philpaw</u>	
14. MOTHER'S MAIDEN NAME: <u>Sarah Pauline Philpaw</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)	
16. SOCIAL SECURITY No.: <u>unknown</u>		17. INFORMANT & ADDRESS: <u>Richard A. R. - Arthur Philpaw</u>	

18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:	INTERVAL BETWEEN ONSET AND DEATH <u>5/24/55</u>
(a) Immediate cause <u>850x</u>	
(b) Antecedent cause(s) <u>Found 6/1/55 at 10 AM</u>	
(c) Diseases or conditions, if any, giving rise to the above cause stating underlying cause last	

II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.	
19a. DATE OF OPERATION: <u>0</u>	19b. MAJOR FINDING OF OPERATION:
20. AUTOPSY? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	21b. PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY <u>Road</u>
21c. City or town <u>Solomon</u> County <u>Calvert</u> (State) <u>MD</u>	21d. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>5-22-55 3:30 AM</u>
21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	21f. HOW DID INJURY OCCUR? <u>Mixed off road</u>
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .	
SIGNATURE <u>H. W. Wang</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAM. <input checked="" type="checkbox"/> DATE SIGNED <u>5/1/55</u>

23. BURIAL, CREMATION, REMOVAL (Specify): <u>Burial</u>	DATE, THEREOF: <u>6/1/55</u>	NAME OF CEMETERY OR CREMATORY: <u>Mount Comfort</u>	LOCATION (City, town, or county) (State): <u>Pa.</u>
DATE REC'D BY LOCAL REG. <u>June 1, 1955</u>	REGISTRAR'S SIGNATURE: <u>Grace L. Hutchins</u>	24. FUNERAL DIRECTOR: <u>Cunningham Funeral Home</u>	ADDRESS: <u>Alexandria, Va.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A16A - 5 - 53



BUREAU V. S.

JUN 13 1955

RECEIVED

4498

04488

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Reg. Dist.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH No. 51

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>H. Beach Md</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town) <u>H. Beach Md</u>		X	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (First) <u>Harry C</u> (Middle) <u>Ranch</u> (Last) <u>Ranch</u>				4. DATE OF DEATH (Month) <u>5</u> (Day) <u>5</u> (Year) <u>1955</u>			
5. SEX: <u>M</u>		6. COLOR OR RACE: <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>W</u>		8. DATE OF BIRTH: <u>June 2, 1875</u>	
9. AGE last birthday: <u>79</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, except retired): <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Md</u>	
12. CITIZEN OF WHAT COUNTRY?				13. FATHER'S NAME: <u>Charles Ranch</u>			
14. MOTHER'S MAIDEN NAME: <u>Heneriths</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>Yes</u> (If Yes, give war or dates of service) <u>WWII</u>			
16. SOCIAL SECURITY No.:				17. INFORMANT & ADDRESS: <u>Carrie Boeckel, H. Beach</u>			
18. MEDICAL CERTIFICATION							INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
434.3 <u>Acute dilatation of heart</u>							
Immediate cause (a) DUE TO							
Antecedent cause(s) (b) DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:							20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
19b. MAJOR FINDING OF OPERATION:							
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. PLACE (Home, farm, factory, street, office, bldg., etc.) OF INJURY <u>Home</u>		21c. (City or town) <u>H. Beach</u> (County) <u>Calvert</u> (State) <u>Md</u>			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE <u>Howard P. M. E.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>5/5/55</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Removed</u>		DATE THEREOF <u>5/5/55</u>		NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		LOCATION (City, town, or county) <u>Wash DC</u> (State)	
DATE REC'D BY LOCAL REG. <u>5/5/55</u>		REGISTRAR'S SIGNATURE <u>Howard</u>		24. FUNERAL DIRECTOR <u>Beal</u>		ADDRESS <u>Wash DC</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MAY 10 1955

RECEIVED

4499

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

04489

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH COUNTY <u>Baltimore</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>North Beach</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Washington D.C.</u>	
TOWN <u>1-yr.</u>		TOWN <u>47X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>1404-8th St</u>		STREET ADDRESS (If rural give location) <u>1806-28th St. S.E.</u>	
3. NAME OF DECEASED (Type or Print)	(First)	(Middle)	(Last)
<u>Berry</u>	<u>E</u>	<u>Swenson</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, (DIVORCED, (Specify)	8. DATE OF BIRTH <u>2/10/1901</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY <u>Sub. Jail</u>	9. AGE last birthday <u>54</u> yrs.	4. DATE OF DEATH <u>May 7</u> 19 <u>55</u>
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	13. FATHER'S NAME <u>Edward Swenson</u>	14. MOTHER'S MAIDEN NAME <u>Mary Brough</u>
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service) <u>Yes</u>	16. SOCIAL SECURITY No. <u>42</u>	17. INFORMANT <u>Edward Smith</u>	

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	INTERVAL BETWEEN ONSET AND DEATH
Immediate cause <u>420.1</u> (a) <u>Coronary occlusion</u>			
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) _____			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. (c) _____			
19a. DATE OF OPERATION <u>5/2</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>	
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 7/1, 1954, to 5/6, 1955, that I last saw the deceased alive on 4/29, 1955, and that death occurred at 1:24 m., from the causes and on the date stated above.

SIGNATURE <u>R. Swenson</u>	(Degree or title)	ADDRESS <u>Mr. Swenson</u>	DATE SIGNED <u>5/7/55</u>
23. BURIAL, CREMATION REMOVAL (Specify)	DATE <u>5/11/55</u>	NAME OF CEMETERY OR CREMATORY <u>Arlington</u>	LOCATION (City, town, or county) (State) <u>Arlington Va.</u>
DATE REC'D BY LOCAL REG. <u>May 7, 1955</u>	REGISTRAR'S SIGNATURE <u>Grace L. Hutchins</u>	24. FUNERAL DIRECTOR <u>Robert A. Mattingly</u>	ADDRESS <u>131-11th St. S.E. Wash. D.C.</u>

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

CERTIFICATE OF DEATH

BUREAU V. S.

MAY 12 1955

RECEIVED

4500

## CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Calvert</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Calvert</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		OR TOWN	
<u>X</u> <u>Lower Marlboro</u>		<u>53 years</u>		<u>Lower Marlboro</u>		<u>X</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE OF DEATH: (Month) (Day) (Year)			
<u>Caroline Elizabeth Wells</u>				<u>May 8 19 55</u>			
5. SEX: <u>Female</u>		6. COLOR OR RACE: <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Married</u>		8. DATE OF BIRTH: <u>April 16, 1871</u>	
9. AGE last birthday: <u>84</u> yrs.		10. MONTHS: <u>8</u>		11. DAYS: <u>19</u>		12. HOURS: <u>55</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY: <u>-----</u>		11. BIRTHPLACE (State or foreign country): <u>Maryland</u>	
13. FATHER'S NAME: <u>Alexander Fowler</u>				14. MOTHER'S MAIDEN NAME: <u>Ann Buckler</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>- - - - -</u>				16. SOCIAL SECURITY No.: <u>- - - - -</u>		17. INFORMANT & ADDRESS: <u>Mr. Oliver Wells, Lower Marlboro, Md.</u>	
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
Interval Between Onset And Death <u>25 years.</u>							
600.0 Immediate cause (a) <u>Recurrent Pyelonephritis</u>							
Antecedent cause(s) (b) <u>Hypertension</u>							
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. DUE TO (c) <u>-----</u>							
11. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION: <u>0</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify)		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
SUICIDE		OF INJURY					
HOMICIDE							
TIME (Month) (Day) (Year) (Hour)		INJURY OCCURRED		HOW DID INJURY OCCUR?			
OF INJURY		While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>					
22. I hereby certify that I attended the deceased from <u>May 6, 1955</u> , to <u>May 8, 1955</u> , that I last saw the deceased alive on <u>May 6, 1955</u> , and that death occurred at <u>5 pm</u> from the causes and on the date stated above.							
SIGNATURE (Degree or title) <u>Grace L. Hutchins</u>				ADDRESS <u>William H. Hutchins, Owings, Maryland</u>			
23. BURIAL, CREMATION, REMOVAL (Specify)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>May 10, 1955</u>		<u>Lower Marlboro Cemetery</u>		<u>Lower Marlboro, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>May 10, 1955</u>		<u>Grace L. Hutchins</u>		<u>William H. Hutchins, Owings, Maryland</u>			

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



BUREAU V. S.

MAY 16 1955

RECEIVED